

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. 38275
Registrar's No. 10001

FILED DEC 2 1948 318
Registration District No.

Primary, Registration District No.

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5700 Kennerly
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

3: (a) PRINT FULL NAME Margaret E. Jenkins
3. (b) If veteran, name war. None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife John B. 6. (c) Age of husband or wife if alive Dec'd years
7. Birth date of deceased May 5 1873 (Month) (Day) (Year)

8. AGE: Years 75 Months 6 Days 12 If less than one day hr. min.

9. Birthplace Kentucky (City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business Self

12. Name Johnson

13. Birthplace Kentucky (City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Maude Geyer

(b) Address 5700 Kennerly

17. (a) Burial (b) Date thereof 11/19/48 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director PROVOST UND. CO.

(b) Address 3710 N. Grand Blvd.

19. (a) NOV 18 1948 (b) J. B. Liscater (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 5700 Kennerly (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 17 year 1948 hour 4 minute 30 A. M.

21. I hereby certify that I attended the deceased from Oct 24 - 48, 19, to Nov 17 - 48, 19, that I last saw her alive on Nov 16 - 48, 19, and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
Due to 92%
Due to

Other conditions Chronic Cardiac asthma (Include pregnancy within 3 months of death)

Major findings: Of operations 2001
Of autopsy 200
PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no accident
(b) Date of occurrence
(c) Where did injury occur? no injury (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? no injury (Specify type of place) (e) Means of injury
While at work? no
23. Signature M. F. Harman (M.D. or other) Address 2239 N. Grand Date signed 11/18/48

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Albert Mayfield*

Licensed Embalmer No. 3077

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.